Tuesday, April 13, 2005

Attachment 2:
MEDICARE MODERNIZATION ACT
STATE EXECUTIVE BRANCH CHECKLIST

SPAPS – STATE PHARMACY ASSISTANCE PROGRAMS

State pharmaceutical assistance programs (SPAPs) are state sponsored programs that provide senior citizens and individuals with disabilities increased access to prescription drugs by paying for or reducing drug coverage. Under the new Medicare Part D drug benefit, an SPAP is defined as a state program that provides financial assistance for supplemental prescription drug coverage for Part D eligible individuals. The states have two options:

- Supplement Medicare beneficiaries' drug coverage by providing its own state supplemental benefit program or purchasing additional benefits through private insurance plans; or
- State SPAPs can contribute to cost sharing that will count towards the beneficiary's true out of pocket expenditures (TrOOP).

Checklist

- ✓ Does your state have a state pharmaceutical assistance program in operation? Was it established by law?
- ✓ Will the state pharmaceutical program be eliminated, scaled back, and/or will it wrap around Part D benefits?
- ✓ Related to wrap around benefits, will the state SPAP help with cost sharing, coordinate with Medicare prescription drug plans, or provide supplemental benefits?
- ✓ How will the state SPAP assist enrollment of clients into the Part D benefit?
- ✓ If an SPAP wraps around Part D, how will true out of pocket costs (TrOOP) be calculated and tracked to ensure the state is only paying for wrap around benefits
- ✓ Have you spoken with your state legislature to determine if you need legislation for program changes?
- ✓ If the SPAP is eliminated or scaled back, what will be done with the savings?
- ✓ If the SPAP is changed and money used for wrap around, what will the budget impact be?
- ✓ How were calculations regarding benefit and administrative costs determined?
- ✓ Is the state receiving transition funds from CMS for its SPAP? How are these funds being spent?

LOW-INCOME SUBSIDY

States are required to take and process applications for the low-income subsidy program, and to screen and offer enrollment into the MSP (these beneficiaries are between 135% and 150% of poverty level and are referred to as QMB, SLMB, QI) program.

Beneficiaries may apply for the Low Income Subsidy (LIS) at the state agency using the SSA application or by requesting the State Medicaid Agency to make a determination

Checklist

- ✓ Is your state agency (Medicaid, eligibility, etc) working with SSA to provide access to the SSA application and eligibility process?
- ✓ Will your state be prepared to begin making eligibility determinations and processing LIS application by July 1, 2005? If yes, what are your plans and/or progress to meet the deadline?
- ✓ Do you have plans for your State Medicaid workers to receive formal training on the eligibility determinations?
- ✓ Has your State developed its own LIS application form?
- ✓ Has your State formalized its procedures for making state LIS eligibility determinations?
- ✓ Has your State developed and implemented its systems requirements?
- ✓ Has your State developed a process to screen and enroll MSP?
- ✓ Beginning in May 2005, SSA will send applications to potential LIS eligibles. Are you ready for an influx of calls and questions at your offices?

OUTREACH AND EDUCATION

States are encouraged to provide outreach and education information to the Medicare beneficiaries in their state. CMS will supply fact sheets, presentations, and other materials for states to use when working with beneficiaries.

Checklist

- ✓ Does your state plan to provide outreach & education about the LIS?
- ✓ Does your state plan to provide outreach & education about the Part D plans beneficiaries can choose?
- ✓ If you do plan to provide outreach and education about LIS and/or the Part D plans, do you have the materials you need to educate beneficiaries?
- ✓ If you do plan to provide outreach and education about LIS and/or the Part D plans, is the appropriate staff trained to educate beneficiaries?
- ✓ Have you spoken with your state legislature about the need for state legislation to coordinate with SSA?
- ✓ Do state agencies that interact with seniors and people with disabilities and their families have a plan for informing clients about the drug benefit?
- ✓ Are there any relationships and or procedures that need to be in place between state agencies and prescriptions drug plans to handle problems, concerns or questions?

DUAL ELIGIBLES

Full benefit dual eligibles will be enrolled in the Medicare drug benefit and therefore lose their Medicaid drug coverage December 31, 2005. Each person will have the opportunity to select the plan of their choice for the Medicare Drug Benefit. They will receive a letter directly from SSA explaining what they must do. They will be auto enrolled into a plan effective January 1, 2006 if they do not choose a plan.

Medicare Savings Program beneficiaries will be facilitated into a plan effective June 2006 if they have not already chosen a plan.

Checklist

- ✓ Does your state plan to "wrap-around" the Part D benefit for Medicaid beneficiaries?
- ✓ If so, have you discussed the need legislation for to provide the wrap-around with your state legislature?
- ✓ Have you budgeted for the additional requirements placed on states by MMA? (increased administrative costs associated with LIS eligibility determinations or increased enrollment in MSP programs?
- ✓ Will you need systems changes for LIS determinations, data exchange, identification of deemed eligible individuals, phasedown contributions, etc.?
- ✓ Is their sufficient funding for the additional staff time need to complete on LIS determinations
- ✓ Does your State Medicaid agency plan to send notices to dual eligibles that will lose their Medicaid prescription coverage?
- ✓ Has your State Medicaid agency been able to identify its Medicaid enrollees that are full dual eligible?
- ✓ Did your State submit the March data file on dual eligibles to CMS?
- ✓ Is your State able to report monthly data accurately to CMS on full duals?
- ✓ CMS plans to provide a state plan pre-print for states to use when amending their Medical Assistance Plans to reflect the implementation of Part D. Will your State Medicaid agency amend its Medical Assistance Plan to reflect the changes accordingly?
- ✓ Has your state considered the need to amend the waivers and/or managed care contracts to remove the drugs covered under Part D?

RETIREE OPTIONS

Under the MMA State Retirement Systems have three options to obtain the Drug Benefit for their beneficiaries. In many cases the state will receive a subsidy of about 28% of the cost of providing the benefit. The states have three options:

- They can set up their own separate supplemental plans and coordinate benefits with the coverage offered by Part D plans, their retirees enroll in to provide extra help with cost sharing in much the say way they currently supplement the standard Medicare Part A and B benefits.
- They can pay for enhanced coverage through a Part D plan to subsidize more of their retirees' cost sharing and provide additional benefits. CMS plans to use its waiver authority to allow sponsors to make special arrangements with Part D plans for, or offer their own part D plans to their retirees. These waivers would allow employers to provide more flexible benefits and to limit enrollment to their retirees.
- Regardless of whether they choose to provide additional coverage that supplements the standard Medicare prescription drug coverage, plan sponsors can also provide extra help by assisting their retirees in paying for some or all of their Part D beneficiary premiums.

Checklist

- ✓ Will the state accept the employer subsidy or adjust benefits for retired state employees to have them enroll in Part D?
- ✓ Is the retired state employee drug coverage equivalent or better than Part D?
- ✓ Who will perform the actuarial analysis required to get the subsidy
- ✓ Which agency gets the subsidy payment from the federal governments and what happens to it?

STATE CONTRIBUTION

MMA requires that states make monthly payments to the federal government to offset a portion of the costs associated with assumption of prescription drug costs by the Medicare program for full benefit dual eligible individuals.

Checklist

- ✓ Have you budgeted for the phase down state contribution payments?
- ✓ Have you provided CMS with the data necessary to calculate the phase down state contribution baseline (Medicaid Statistical Information System (MSIS) reporting for CY 2003)?
- ✓ Is the state on track to be able to provide the monthly dual eligible enrollment data needed to support the phase down enrollment counts?

GENERAL

State Insurance Laws and Regulations

- ✓ Is the state insurance commissioner aware of the changes to Medigap brought about by MMA?

- ✓ Does the state insurance commissioner know of any changes to state insurance laws necessary to conform to the new MMA legislation?